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EDITORIAL

Tackling ethnic inequalities in asthma. We now need results

Ethnic minority groups continue to experience poorer health outcomes compared with majority groups for a range of chronic diseases, including respiratory disorders.[1] For asthma, poorer health outcomes for minority ethnic groups have been a universal finding.[2–5] In New York, for example, a Black person with asthma is up to nine times more likely to die from asthma than a person from other ethnic groups,[4] whilst in the UK emergency hospital admission rates for asthma in South Asians and Blacks have significantly exceeded those of Whites, despite broadly comparable prevalences of asthma.[5]

Reducing health inequalities experienced by ethnic minority groups is a stated government priority.[6] Despite having the world's highest prevalence of asthma,[7] the UK suffers from a haphazard and piecemeal approach to respiratory research and policy; one which is as a consequence unlikely to achieve the desired equitable disease outcomes. Rather, what is needed is a strategic co-ordinated research programme that provides the necessary epidemiological evidence and in-depth understanding of asthma and asthma care as experienced by ethnic minority communities to develop and evaluate rigorously the effectiveness of interventions aiming to improve outcomes in these disadvantaged groups.

But what precisely are the research priorities?

Firstly, there is a need for more up-to-date and comprehensive data on the incidence, prevalence, morbidity and mortality from asthma in different ethnic groups. Much of the epidemiological evidence currently available is dated, and even that which is forthcoming, is in the main confined to children. We know very little, if anything, about patterns of asthma and disease outcomes in Chinese, Turkish and Somali populations, for example, all of whom are now represented in sizeable numbers in the UK.[8]

The welcome drive to ensure that ethnicity coding is made routine throughout the National Health Service should, through unlocking the potential of routinely collected data, certainly help in this task. More sophisticated linkage of datasets could then help to define the relative contributions of ethnicity, poverty and uneven access and service delivery to adverse asthma-related health and social outcomes. There is however also the need for primary epidemiological studies which, in particular, aim to unpick the gene–environment interactions that might in part be responsible for determining differences in susceptibility and outcomes.[9] Armed with such data we should be in a position to prioritise and focus efforts to begin reducing inequalities.

Secondly, there is need for a more in-depth understanding of health-seeking behaviours and the clinical experiences of different ethnic groups. What are the social and psychological implications of a diagnosis of asthma and how may beliefs and attitudes to the need for long-term prescribed treatments vary across and within ethnic groups, for example? Similarly, what will be the impact of developments such as pharmacist prescribing,

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self-management plans and e-consulting on improving access and promoting self-empowerment in different ethnic communities? What are the relative merits of lay ('expert patient') and professionally led educational initiatives and how can these be integrated into provision of care for multi-ethnic populations? How will the progressive fragmentation of primary care services affect access to care for minority ethnic groups? Will new initiatives benefit the majority White population preferentially, so perversely widening inequalities further? And how does racism (within and without the health service) affect people's asthma care?[10] An in-depth understanding of these (and other) areas is likely to be fundamental to developing interventions that have face-validity to the communities concerned.

Interventions addressing health behaviours are likely to be complex.[11] Qualitative analyses identifying relationships between explanatory models of disease, health behaviour and health service use have a key role to play prior to developing interventions. Qualitative work in east London suggests that poor outcomes for South Asians may reflect a combination of poorer access to primary care,[12] differences in the therapeutic relationships developed between clinicians and patients, and contrasting explanatory models (particularly in Bangladeshi Muslims) emphasising spiritual over structural aetiologies of asthma.[13]

Thirdly, we need to conduct evaluative studies. There are however important barriers to overcome; these include ensuring that ethnic minority participants are recruited in sufficient numbers (where appropriate) to allow meaningful ethnic specific evaluations of effectiveness.[14] But trials comparing outcomes between groups need to be large and will in addition to good strategies for recruitment also require commitment from funders. Extra incentives may be needed to induce participation of general practices in socially deprived areas. Having a suitable range of culturally adapted and validated respiratory instruments with which to assess outcomes is a prerequisite for comparing outcomes that go beyond health service use.[15]

Although we have now known about ethnic inequalities in asthma outcomes for some two decades there has, regrettably, been very little progress in improving asthma outcomes in disadvantaged groups. We believe that each of the three strands of work outlined above now needs to be prioritised by research charities and the Department of Health for what is one of the commonest chronic disorders in Britain. But reducing health inequalities between ethnic groups requires not only good research: also needed is assertive action by governments.[16] Bhopal puts it succinctly: 'Equity is the core ethical principle underpinning discussions of ethnicity and health care. An equitable health service needs to meet equal needs equally.'[17] Until health outcomes are similar across ethnic groups, health services will be failing this test.

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Aziz Sheikh
Primary Care Research & Development, Division of Community Health Sciences: GP Section, University of Edinburgh, 20, West Richmond St, Edinburgh, EH8 9DX UK
E-mail address: aziz.sheikh@ed.ac.uk

Chris Griffiths
Department of General Practice and Primary Care, Queen Mary's, University of London, UK